

The Future: Policy Issues Confronting Washington State

ISSUES

Alcoholism as a
Chronic Disease

Brief Interventions
in Emergency Dept.
& Health Care Settings

Criminal
Justice

Opiate
Substitution
Treatment

Substance
Abuse and
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Treatment for
Nicotine
Dependence

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Alcohol consumption in Washington State is at its lowest point in more than two decades. At the same time, chronic drinking rates are at the highest point in more than a decade, as are deaths due to chronic liver disease and cirrhosis. Alcohol abuse and alcoholism remain the number one substance abuse problem in Washington State. Alcoholism bears strong similarities to other chronic health problems such as asthma, diabetes, and high blood pressure.

Per capita alcohol consumption, both in Washington State and the nation, has been dropping steadily since 1980. In Washington State, most of that reduction has been in the consumption of hard liquor.¹ Yet at the same time, chronic drinking rates among Washington State adults appear to be on the rise, and the state has had a consistently higher alcohol-induced death rate than the nation. Deaths due to chronic liver disease and cirrhosis, closely associated with long-term alcohol use, are at their highest point in a decade. The total social and economic costs of alcohol abuse and alcoholism in the United States, estimated at \$184.6 billion, are approximately 50% greater than costs related to abuse of all illicit drugs combined.²

Shorter-Term Problems

Problems associated with alcohol use can be divided, although not cleanly, into those associated with shorter-term and longer-term, or chronic, use. Alcohol abuse -- either short-term, intermittent, or binge drinking -- is linked with deaths from traffic crashes, falls, fires, and drowning. It is also associated with homicide, suicide, domestic violence, family disruption, and child abuse.³ Binge drinking is also directly related to alcohol poisoning and blackouts. Intermittent use during pregnancy is associated with fetal and infant deaths, low birth weight births, and fetal alcohol syndrome and fetal alcohol effects. Light and moderate alcohol use is associated with 60% of alcohol-related absenteeism, lower worker productivity, and workplace accidents.⁴

Alcoholism as a Chronic Disease

Among young people, alcohol use is also associated with negative academic performance. Students who drink are more likely to have lower grades, cut classes, become truant, and are much more likely to drop out of school. Studies indicate that alcohol-dependent teens manifest impaired memory, altered perceptions of spatial relationships, and verbal skill deficiencies. Young people are also more likely to sustain brain damage as a result of alcohol abuse.⁵ According to a recent study published in the *Journal of the American Medical Association*, underage drinkers account for 19.7% of all alcohol consumed in the United States.⁶

Alcoholism – Associated Medical Problems

Of the approximately 17.6 million Americans who abuse alcohol, some 7.9 million (almost 45%) suffer from alcoholism, a chronic disease, characterized both by addiction and association with a long list of medical problems affecting virtual every organ system in the body.⁷ These include:

- High blood pressure (hypertension);
- Large red blood cell anemia;
- Decreased production and efficiency of white cells;
- Decreased production of clotting factors and platelets;
- Heart rhythm irregularities (arrhythmias);
- Heart muscle disorders (cardiomyopathy);
- Heart attacks;
- Stroke;
- Cancers of the mouth, pharynx, larynx, and esophagus;
- Breast cancer;

- Ulcers and gastritis;
- Gastro-esophageal hemorrhage;
- Impaired immune system, leading to increased susceptibility to infections, including pneumonia, tuberculosis, and septicemia;
- Cirrhosis;
- Acute and chronic inflammation of the pancreas;
- Worsening symptoms of mental illness and interference with treatment;
- Compromised sexual function; and
- Reduced bone density and increasing risk of fractures.

Alcohol is an addictive drug. Over time, its use can lead to craving, increased tolerance, and impaired control. As this occurs, medical complications increase, as individuals must access treatment both for the associated medical conditions and their underlying cause.

Alcoholism as a Chronic Disease

A chronic disease is one that continues over a long time, progressing either consistently or intermittently. It often can be managed, and is likely to worsen without treatment. The causes of chronic disease can be complex, triggered in different ways, and include hereditary factors. The course of chronic diseases may be unpredictable. Treatment may require that patients change their behavior, and some patients may relapse more frequently than others.

This description closely fits alcoholism. It also describes other chronic diseases such as asthma, diabetes, and high blood pressure.

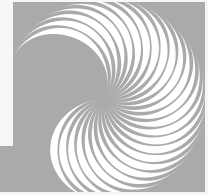
The resemblances among these chronic diseases are striking. Genetics play a heavy role in each, causing individuals to become vulnerable. In the case of alcoholism, studies suggest that genetic factors account for 50-60% of the propensity toward the disease. People who are at genetic risk for asthma, diabetes, high blood pressure, and alcoholism can control certain risk factors. Doing so in the case of alcoholism by choosing not to drink may be more difficult than for other diseases, especially among young people, as social encouragement to use alcohol is widespread. Over time, there is strong evidence that drinking by alcoholics negatively impacts brain chemistry, making it increasingly difficult for individuals to control their disease.

Like asthma, diabetes, and high blood pressure, there is no known cure for alcoholism, but there are clear diagnostic criteria, research-based treatment guidelines and protocols, and proven effective patient and family educational interventions. Following treatment, a higher percentage of patients with alcoholism follow treatment regimens faithfully than do those with other chronic diseases. Relapse rates for alcoholism are no higher, and in some cases, lower than for other chronic diseases.

Four Steps Toward Dealing with Alcoholism as a Chronic Disease

1. Prevention

The most effective public health approach to chronic diseases is to prevent them before they make their appearance. With the aid of the Division of Alcohol and Substance Abuse (DASA) and the Western Center for the Application of Prevention Technology, schools and community coalitions across Washington are applying evidenced-based practices to the prevention of alcohol abuse and alcoholism among youth. These range from *universal* prevention approaches





aimed at entire populations – whether in schools or communities, to *selective* prevention targeting those who are at high-risk for alcohol abuse, to *indicated* approaches aimed at those for whom abuse has already started.

In Washington State, the prevention field makes use of the risk-and-protective framework pioneered by University of Washington researchers Drs. David Hawkins and Richard Catalano. By isolating those factors that put young people at particular risk for substance abuse, and those factors that are protective, the framework enables schools and communities to develop a chain of inference in choosing prevention applications likely to result in reduced levels of alcohol use.

Other factors affecting youth use of alcohol and the long-term progression to alcoholism include price, availability, and advertising, which makes drinking appear glamorous and appealing. New approaches to youth alcohol consumption, such as social marketing, which has been pioneered at Western Washington University, show promise in changing the culture of drinking on college and university campuses, weakening the links between early abuse and the progression to a chronic disease condition.

2. Brief Interventions

As the progression from alcohol abuse to the chronic disease of alcoholism may be slow, individuals may not be fully aware of their symptoms. It is sometimes possible to intervene opportunistically in the life of the alcohol abuser and engage awareness of the need to limit consumption or eliminate it all together, without the need for substance abuse treatment.

Dr. Larry Gentilello conducted a study of patients admitted to the trauma center at Harborview Medical Center. Of 2,524 patients screened, 1,153 (46%) were found to have signs indicative of an alcohol-related problem. Patients

were assigned to two groups: those receiving no follow-up for their alcohol-related problem, and those who received a single motivational interview with a psychologist trained in the use of brief interventions. A focus was placed on the patient's assuming personal responsibility for reducing drinking to decrease his or her level of risk. A menu of strategies was provided, including a list of treatment resources and self-help groups in the community. At the 12-month follow-up, those who received the intervention decreased alcohol consumption by an average of 21.8 alcoholic drinks per week. At the three-year follow-up, they experienced a 47% reduction in injuries requiring emergency department or trauma center admission, and a 48% reduction in injuries requiring hospital admission.⁸

In 2003, the Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA) received a \$16.1 million 5-year grant from the federal Substance Abuse and Mental Health Services (SAMHSA), Center for Substance Abuse Treatment (CSAT) to implement the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program. As a result of the grant, chemical dependency professionals (CDPs) are now working in hospital emergency rooms in Seattle, Tacoma, Everett, Yakima, and Vancouver to screen and refer patients to treatment. WASBIRT is expected to provide services to 184,620 people during the period of the grant at Harborview Medical Center, Tacoma General Hospital, Providence Everett Medical Center, Southwest Washington Medical Center, Yakima Regional Medical Center, and Toppenish Community Hospital.

Similar opportunities for brief interventions exist in regular visits to doctors' offices. It is estimated, however, that fewer than 30% of primary care physicians screen their patients for health problems related to their use of alcohol. Opportunities for brief interventions also exist in the workplace, especially through the use of Employee Assistance Programs.



3. Reducing Stigma

“Changing the Conversation”, the federal Center of Substance Abuse Treatment’s “National Treatment Plan Initiative”, singled out stigma as a powerful, shame-based mark of disgrace and reproach that impedes treatment and recovery. Stigma prevents widespread recognition of alcoholism as a chronic disease. Because of the stigma attached to it, physicians, insurance companies, and even state governments fail to acknowledge alcoholism as a medical problem. Stigma often prevents individuals from seeking care for their addiction.

It should be noticed that the stigma attached to alcoholism has some subtle differences from that attached to drug addiction. Society often views drug addiction as first and foremost a criminal justice problem, and hence those addicted are viewed as criminals, thus hampering both assessment of, and treatment for the condition. In contrast, alcohol use is legal, widespread, and often socially encouraged. Those afflicted with a chronic disease related to its use may be ostracized as “weak-willed” or “lacking in self-control”.

Changing the Conversation proposes a four-step approach to reduce stigma and change attitudes about people at risk for, in need of treatment for, or in recovery from alcoholism (and drug addiction):

- Conduct science-based marketing research (i.e., polling surveys, focus groups) to provide the basis for a social marketing plan;
- Based on the results of the research, implement a social marketing plan designed to change knowledge, attitudes, beliefs, and behavior of individuals and institutions to reduce stigma and its negative consequences;

- Facilitate and support grassroots efforts to build the capacity of the recovery community to participate in the public dialogue about addiction, treatment, and recovery;
- Promote the reduction of stigma and discrimination against people in treatment or in recovery by encouraging respect for their rights in a manner similar to that afforded to people who suffer from and overcome other chronic diseases.

4. Increasing Availability of Treatment

There is a huge gap between those who both qualify for treatment for alcoholism and are in need of it and those who actually receive it. Alcoholism among those with private health insurance that would cover treatment often goes untreated, as more than two-thirds of physicians do not offer appropriate screening and referral. Because of stigma, individuals may deny that they suffer from this debilitating disease, or refuse to seek treatment. Individuals may be reluctant to use Employee Assistance Programs or, in some cases, even their health insurance, for fear that confidentiality may be compromised.

Alcohol is consistently cited as the primary drug of abuse in a large plurality (47%) of adult admissions to DASA-funded treatment. But the treatment gap is such that some 79.2% of adults in need of, and who qualify for DASA-funded treatment (for all drugs, including alcohol) do not receive it. Such levels of unmet need in dealing with any other chronic disease condition would likely be considered medical malpractice.



As treatment providers become increasingly effective in retaining patients until they complete their treatment plans, the number of admissions to publicly funded treatment is likely to decline. DASA-funded admissions to treatment for alcoholism reached their peak in SFY 1999 (17,516) and have been declining steadily since (to 14,186 in SFY 2003). Waiting lists for treatment under the Alcohol and Drug Abuse

Treatment and Support Act have quadrupled since 1991, and have accelerated greatly in the past four years. A new commitment to the funding of quality alcoholism treatment services will be necessary if Washington State is to realize the promise of our ability to turn the tide against the chronic disease that afflicts so many of our citizens.

¹ National Institute on Alcohol Abuse and Alcoholism, *Per Capita Ethanol Consumption for States, Census Regions, and the United States, 1970-1999*.

² National Institute on Alcohol Abuse and Alcoholism, *10th Special Report to Congress on Alcohol and Health*. Washington, DC: Department of Health and Human Services, 2000.

³ U.S. Department of Health and Human Services, *Healthy People 2010* (Conference Edition), 26-4. Washington, DC: 2000.

⁴ Mangione, T., Howland, J., and Lee, M., *New Perspectives for Worksite Alcohol Strategies: Results from a Corporate Drinking Study*. Washington, DC: National Institute on Alcohol Abuse and Alcoholism, 1998.

⁵ Center for Substance Abuse Prevention, "Underage Drinking and Academic Performance," *Prevention Alert*, Vol. 5 No. 12, September 27, 2002.

⁶ Foster, S. et. al., "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association*, 289 (8), February 26, 2003.

⁷ Grant, B. , et al., *2001-2002 National Epidemiological Survey on Alcohol and Related Conditions*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, 2004.

⁸ Gentilello, L., et al., "Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence," *Annals of Surgery* 230 (4), July 1999.

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Brief Interventions in Emergency Department and Health Care Settings

Traumatic injury inflicts enormous medical and psychosocial harm on its victims. The greatest underlying cause of injury is the misuse of alcohol and drugs.¹ By intervening in the substance abuse of individuals who frequent emergency departments, alcohol/drug abuse can be reduced, as can injuries requiring emergency department admissions.

Substantial numbers of individuals who visit hospital emergency departments (EDs) present with a diagnosis or injury caused by substance use or abuse disorders. A 2004 study found that nationally between 1992 and 2000, there was an average of 7.6 million ED visits per year for alcohol alone, or 7.9% of all such visits. This is approximately three times higher than previously estimated, based on physician documentation or patient disclosure of alcohol involvement.² It has been estimated that 20-50% of primary care patients may abuse alcohol or drugs and go undetected by their provider.

A wide range of effective treatments has been developed for mild, moderate, and severe drug and alcohol problems. Prior studies have shown that interventions, when delivered to injured patients in hospital EDs and in the inpatient units of hospitals, can reduce alcohol and drug consumption, prevent re-injury, and help patients with more severe problems access intensive, community-based chemical dependency treatment. These services demonstrate that counseling and referral helps reduce adverse health outcomes, reduces cost for medical care, reduces future emergency room use, reduces criminal justice involvement, and improves employment outcomes.

A study conducted at the trauma center at Harborview Hospital in Seattle found that of 2,524 patients screened, 1,153 or 46% tested positive for alcohol abuse. Patients were then randomized either to a control group, or to receive a brief onsite intervention related to the patients' drinking, including information about the risks of alcohol abuse and the availability of treatment resources. At the 12-month fol-

lowup, the intervention group had decreased alcohol consumption by an average of 21.8 drinks per week. At the three-year followup, there had been a 47% reduction in injuries requiring either emergency department or trauma center admission, and a 48% reduction in injuries requiring hospital admission.³

Besides reducing injuries and future ED admissions, early identification of alcohol and drug problems and brief intervention is, in some instances, an effective and cost-saving alternative to more intensive chemical dependency treatment. Early identification of alcohol and drug problems holds out the hope of preventing the progression of chronic substance abuse dependence.

Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT)

In 2003, the Department of Social and Health Services, Division of Alcohol and Substance Abuse (DASA) received a \$16.1 million, 5-year grant from the federal Substance Abuse and Mental Health Services (SAMHSA), Center For Substance Abuse Treatment (CSAT) to implement the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program.

The goals of WASBIRT are to:

- Provide substance abuse screening in three EDs in two Washington State communities, thereby identifying a large number of patients who have substance abuse problems of all severity levels;
- Deliver brief interventions in EDs to patients admitted to the hospital who are not dependent, but whose misuse places them at increased risk for future re-injury or hospitalization;

- Provide brief treatment (5-12 sessions) on an outpatient basis to some patients who need and want more intensive, brief preventive treatment;
- Increase the number of referrals made to community-based chemical dependency treatment for patients dependent on alcohol and other drugs;
- Reduce subsequent ED utilization, medical costs, criminal behavior, disability, and death by patients with drug and alcohol problems of all severity level; and,
- Involve a multitude of perspectives to explore systems change to improve existing linkages to these services, and to expand substance abuse services to include early intervention.

As a result of the grant, chemical dependency professionals (CDPs) are now working in hospital emergency rooms in Seattle, Tacoma, Everett, Yakima, and Vancouver to screen and refer patients.

WASBIRT is expected to provide services to 184,620 people during the period of the grant at Harborview Medical Center, Tacoma General Hospital, Providence Everett Medical Center, Southwest Washington Medical Center, Yakima Regional Medical Center, and Toppenish Community Hospital.

“Teachable Moments”

In some ways, EDs and trauma centers are ideal sites in which to provide people who drink or use illicit drugs in harmful or hazardous patterns with a targeted intervention at the time of an adverse event—a situation sometimes referred to as a “teachable moment.” The WASBIRT program extends beyond the brief intervention model by providing timely and appropriate referral to more intensive substance abuse treatment where appropriate.

Prior research has demonstrated this to be an effective approach. A 2001 study showed that of 719 patients provided a direct referral to substance abuse treatment over a one-year period, some 80% made contact with the treatment facility, and 78% were admitted to treatment. The negative consequences associated with an ED visit often serve as prime motivators to move patients toward dealing with their substance abuse problems.

It is anticipated that implementation of screening, brief intervention, and referral will result in better health outcomes for patients, and will benefit participating hospitals and communities impacted by these services. Participating hospitals should experience a decrease in hospital ED admissions and hospital admissions caused by use and abuse of alcohol and other drugs and reduced costs associated with those admissions. Communities should be safer, as fewer injury-related events associated with substance abuse are likely to occur. A 1999 study found that within six months of ED brief interventions for alcohol-related problems among older adolescents, there was a 27% reduction in drinking and driving, an 87% reduction in moving violations, and a 58% reduction in alcohol-related injuries.⁴

Missed Opportunities

While EDs provide an excellent venue for intervening in a patient’s substance abuse, the visit to the ED is often late in the chain of opportunities for such intervention. Multiple studies have demonstrated the efficacy of brief intervention in a variety of settings, most notably primary care offices and health care clinics.⁵

Often, however, those opportunities are missed. A 2000 survey of primary care physicians and patients published by the National Center on Addiction and Substance Abuse at Columbia University found that 94% of primary care physicians misdiagnose or fail to diagnose substance abuse when





presented with early symptoms of alcohol abuse in adult patients. Only 19.2% of physicians felt themselves “very prepared” to diagnose alcoholism, and the percentage was lower for illegal drugs (16.9%). Fewer than a third (32.1%) of primary care physicians screen for substance abuse. Reasons cited for physicians failing to make use of intervention opportunities include: lack of adequate training in medical school or continuing education; lack of knowledge of treatment effectiveness; discomfort discussing substance abuse; time constraints; and patient resistance.⁶ A 2004 study found that, of the 7% of patients admitted to hospitals who had indications of alcohol disorders, fewer than half were so diagnosed in their hospital records.⁷

Future Challenges

DASA will continue to pursue opportunities to expand the WASBIRT model into additional EDs and trauma care centers. At the same time, hospitals, health insurers, and health maintenance organizations would do well to examine the cost offsets associated with providing screening, brief intervention, and treatment services for all individuals who enter

EDs. It is likely that the cost of training physicians and other health care professionals to provide appropriate interventions and referrals would be more than offset by decreased ED and hospital utilization.

There is also a substantial need for improved training of health care providers, both in their initial, residency, and continuing educations, on issues related to substance abuse. County medical associations could play an important role in facilitating the education of health care providers about the impact of brief interventions and the availability of community-based treatment resources.

Perhaps most important are efforts to mitigate the effects of stigma on patients, providers, and health care systems. Once substance abuse prevention and treatment efforts are considered part of larger array of health care services, and regularly provided as appropriate, it is likely that overall health care costs will be significantly reduced, and the health of individuals, families, and communities will be significantly enhanced.

¹ *Alcohol and Other Drug Screening of Hospitalized Trauma Patients*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, TIP 16, Printed 1995

² Alden, J., Wang, N., & Camargo, C., “U.S. Emergency Department Visits for Alcohol-Related Diseases and Injuries Between 1992 and 2000,” *Archives of Internal Medicine* Vol. 164 No. 5, March 8, 2004.

³ Gentilello, L., et al., “Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence,” *Annals of Surgery* 230(4), October 1999.

⁴ Monti, P., et al., “Brief Intervention for Harm Reduction with Alcohol-Positive Older Adolescents in a Hospital Emergency Department,” *Journal of Consulting and Clinical Psychology* 67(6), 1999.

⁵ Fleming, M., et al., “Brief Physician Advice for Problem Alcohol Drinkers,” *Journal of the American Medical Association* Vol. 277, 1997.

⁶ The National Center on Addiction and Substance Abuse at Columbia University, *Missed Opportunity: The CASA National Survey of Primary Care Physicians and Patients*. New York, NY: 2000.

⁷ Smothers, B., Yahr, H., & Ruhl, C., “Detection of Alcohol Use Disorders in General Hospital Admissions in the United States,” *Archives of Internal Medicine*, 164(7), April 12, 2004.

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Criminal Justice

Substance-abusing offenders are the majority of Washington's prison population. The cost to the state in incarcerating these offenders has increased radically in the past two decades. New criminal justice reforms, including a strong commitment to treatment, hold out the promised of reduced incarceration, recidivism, and greater public health and safety.

The last two decades have witnessed substantial increases in the number of drug-related offense cases in both Washington State and across the nation. Coupled with punitive state and federal sanctions for drug possession, manufacturing, and distribution, these increases have contributed significantly to the problems faced by already overtaxed law enforcement agencies and courts, and overcrowded jails and prisons. Additionally, there have been significant increases in the number of substance-abusing offenders serving time for non-drug-related offenses.

Since the July 1, 1984, implementation of the Sentencing Reform Act of 1981 (SRA), the Washington State Legislature has amended adult felony sentencing law in every legislative session except 1985. From State Fiscal Year 1985-2003, the number of drug offenders in state prisons increased well over 1,700%, from 173 to 3,253. Of the 16,520 offenders in state prisons at the end of SFY 2003, 19.7% were drug offenders (compared to 2.6% at the end of SFY 1985).

While drug offenders make up an ever-increasing percentage of the state's prison population, they are not the only offenders in need of substance abuse treatment. The Department of Corrections (DOC) estimates that 60-80% of inmates are in need of substance abuse treatment. Only a fraction receive treatment.

Without appropriate treatment, substance-abusing offenders, once released, are more likely to re-offend and, therefore, will be returned to prison. The operational costs of incarcerating these offenders, and the costs of servicing the

debt associated with the capital expansion needed to create beds for the continually increasing inmate population, are overwhelming. The operational costs alone of incarcerating drug offenders has increased from \$3.0 million in SFY 1985 to \$89.1 million in SFY 2003 – an increase of over 3,000% since the implementation of the SRA. This does not include operational costs for other substance-abusing offenders; nor does it include any capital expenditures.

Additionally, none of the above takes into account the costs to victims, or to law enforcement, courts, and local jails in dealing with substance-abusing offenders. Adult and juvenile arrests for drug offenses alone increased from 17,248 in 1993, to 27,925 in 2003, representing a 62.2% increase.

It has become increasingly clear to criminal justice personnel and policymakers that the traditional means of adjudicating and punishing non-violent drug-abusing offenders, while expensive, has not worked effectively. It has done little to reduce criminal recidivism, curtail drug use, or enhance public safety.

The Effectiveness of Treatment

As the cost of incarcerating offenders has risen, there has been a growing awareness of the effectiveness of substance abuse treatment in reducing recidivism and costs. A 2002 study of patients receiving publicly funded treatment in Washington State examined arrest records before and after treatment. The study found:

- A 21% decline in the number of patients arrested following treatment;
- A 33% decline in the number of arrests for felony offenses following treatment; and
- Reduced risk of felony arrests for patients that complete treatment and for those with longer stays.¹



A review of all drug court evaluation studies in the United States undertaken by the Washington Institute for Public Policy concluded that drug courts save nearly three dollars for every dollar of taxpayer expenditure when factoring in victim costs, and they reduce recidivism (compared to standard courts) from 45.8% to 39.7%, representing a decrease of 13.3%.² Providing treatment to substance-abusing offenders benefits offenders, the criminal justice system, taxpayers, and communities.

Drug Courts

The strategy behind drug courts is to use the coercive power of the criminal justice system to force substance abusing offenders to undergo chemical dependency treatment. By treating substance abuse problems, criminal recidivism and the associated criminal justice costs, as well as the greater social and economic costs associated with substance abuse, can be reduced.

The first drug courts began operation in Washington State in 1994. As of July 2004, there are adult drug courts in the following communities:

Counties:

Benton-Franklin	Kitsap	Snohomish
Clallam	Kittitas	Spokane
Clark	Lewis	Thurston
Cowlitz	Mason	Whatcom
Jefferson	Pierce	Yakima
King	Skagit	

Federally Recognized Tribes:

Lummi
Makah
Spokane
Yakima Indian Nation

In addition to adult and tribal drug courts, there are juvenile, youth-at-risk, misdemeanor, dependency and family treatment courts, all using the drug court model. King County operates a mental health court that utilizes the drug court model to serve mentally ill offenders. Overall, Washington has 30 operating non-tribal and tribal drug courts, two mental health courts, and 14 drug courts in the planning stages. Additionally, drug courts will be a primary mechanism for providing judicially supervised treatment under the new criminal justice reform measures.

Adult Offenders

Drug Offender Sentencing Reform

With bipartisan support, Second Substitute House Bill 2338 was passed by the 2002 Legislature and signed into law by Governor Locke. The law effects major changes in drug offender sentencing in Washington State. Key provisions of the new law include:

- Establishing the Criminal Justice Treatment Account (CJTA), funded out of savings to the Department of Corrections by reducing sentences for certain drug offenders;
- Utilizing savings for treatment and limited treatment support services;
- Establishing work groups to develop a methodology for calculating the savings; formulas and grant processes for distributing the funds to the counties; and county plans for submission to the formula and grant panels;
- Establishing a drug offender sentencing grid and a review committee;
- Setting minimum standards for the participation of offenders in drug courts; and



- Authorizing studies of the effectiveness of the new sentencing grid and drug courts.

Under the new statute, resultant prison bed savings are to be calculated for each biennium. Beginning July 1, 2005, \$8,250,000 per fiscal year will be transferred from the General Fund to the CJTA. The money transferred to the CJTA will be distributed by the Division of Alcohol and Substance Abuse to counties (70% using a funding formula, and 30% through a grant program) for use in providing substance abuse treatment for offenders at the local level. Additional funds will be transferred to the Department of Corrections for the purpose of substance abuse treatment services for offenders confined to state prisons. Some 5,500 offenders are expected to receive treatment during the 2005-2007 Biennium as a result of CJTA.

Since the statute became effective, continuous progress has been made toward implementation of its provisions. All of the work groups and committees established by the bill have been formed and have been working toward their assigned goals. The work group charged with developing a methodology for calculating the biennial savings under the bill has completed that task, as demonstrated by the estimated savings shown above. The CJTA Panel has established a formula – utilizing combination of the percentage of at-risk adults (age 18 to 54) in each county at or below 200% of the Federal Poverty Line, the number of certain felony and misdemeanor filings in each county, and the percentage of adults in each county at or below 200% of the Federal Poverty Line who are in need of treatment – to distribute 70% of the CJTA funds. The Panel has also established criteria for distributing the other 30% of the money via grants, and is currently in the process of reviewing the grant applications to determine which counties will receive grant funds.

Drug Offender Sentencing Alternative

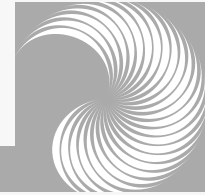
The Drug Offender Sentencing Alternative (DOSA) is an adult felony sentencing alternative aimed at providing substance abuse treatment for certain offenders. An offender is eligible for DOSA if:

- (s)he is convicted of a felony that carries a standard range of more than one year;
- the felony is not a sex offense or a violent offense and does not involve a weapon enhancement;
- the offender has no prior convictions for a sex offense or a violent offense, and is not subject to a deportation detainer or order; and
- if the offense is a drug offense, the quantity of the drug involved is small.

If an eligible offender is sentenced under DOSA, the offender receives a prison term that is one-half of the midpoint of the standard sentence range in length, community custody for the remainder, and must meet various other conditions. While the offender is serving the term of confinement, (s)he undergoes a comprehensive substance abuse assessment and receives appropriate treatment. Some 3,012 offenders received chemical dependency treatment under DOSA in SFY 2002.

Department of Corrections

While offenders sentenced under DOSA are given priority for substance abuse treatment services in DOC, they are not the only offenders who receive treatment. Any offender under the supervision of DOC assessed as having substance abuse problems may be eligible for treatment. Substance abuse treatment services are provided to about 6,000 offenders annually, at 33 locations throughout the state. Services



offered include long-term residential (in the form of modified therapeutic communities), intensive outpatient, and standard outpatient treatment. Additionally, specialized dual-diagnosis, maintenance, and gender-specific treatment tracks are being developed. Offenders in correctional facilities or under supervision in the community are both eligible for treatment.

City and County Jails

Many of the local jails in Washington State provide some form of substance abuse treatment for incarcerated offenders. Based upon a 1999 survey of the 37 county jails and 20 city jails operating: 13 county jails offered drug and alcohol education or awareness, 16 county jails and three city jails provided for non-medical detoxification, 35 county jails and seven city jails offered substance abuse self-help group programs, and 12 county jails provided additional substance abuse treatment.³

Juvenile Offenders

Juvenile Rehabilitation Administration

The Juvenile Rehabilitation Administration (JRA) estimates that 75.3% of youth entering its facilities have substance abuse-related problems.⁴ JRA has adopted an integrated service model to develop and implement substance abuse programming, with a primary goal of reducing recidivism through the early identification and treatment of chemical abuse. Among the substance abuse services provided by JRA are: screening, assessment, and diagnosis; substance abuse education; inpatient and intensive outpatient treatment at several facilities, recovery house services at one facility; and transitional and aftercare treatment services. Approximately 96 youths are served each month.

Chemical Dependency Disposition Alternative

The Chemical Dependency Disposition Alternative (CDDA) provides juvenile courts with a sentencing option for substance-abusing juvenile offenders, allowing judges to order youth into treatment instead of confinement. A juvenile is eligible for CDDA if (s)he has committed a specific type of offense subject to a standard range disposition of local sanctions or 15-36 weeks of confinement, and has a substance abuse problem. Under CDDA, the court imposes the standard range sentence or raises it, suspends the disposition, places the offender on community supervision for up to one year, orders outpatient and/or inpatient substance abuse treatment, and may impose up to 30 days of confinement, 150 hours of community restitution, and payment of legal financial obligations and restitution.

CDDA represents a collaboration between the Juvenile Rehabilitation Administration (JRA), Medical Assistance Administration, DASA, local juvenile courts, the University of Washington and county alcohol/drug coordinators. According to JRA, 568 juveniles received chemical dependency treatment under CDDA in SFY 2003.

Local Juvenile Detention Facilities

Most local juvenile detention facilities in Washington State offer some form of substance abuse treatment. Based upon a 1999 survey of local juvenile detention facilities in Washington State, 19 of the 21 operating facilities offered substance abuse treatment: 11 offered substance abuse treatment under the CDDA program; 17 offered substance abuse self-help group programs; nine facilities had non-CDDA certified outpatient treatment; and 12 facilities provided additional forms of substance abuse.⁵

¹ Washington State Department of Social and Health Services, Research & Data Analysis Division. *Fact Sheet 4.42*. Olympia, WA: March 2002.

² Washington State Institute for Public Policy, *Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefit Analysis*. Olympia, WA: March 2003.

³ Vukich, E. and Daniels, K., *City and County Jails in the State of Washington: The Washington State Master Capacity Plan Snapshot Report*. Olympia, WA: Washington Association of Sheriffs and Police Chiefs, Washington State Department of Corrections, Washington State Sentencing Guidelines Commission, 2000.

⁴ Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, May 2004.

⁵ Vukich, E., *Juvenile Detention in Washington State: Population, Capacity and Programming in Local Facilities*. Olympia, WA: Washington State Sentencing Guidelines Commission, 2000.

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Opiate substitution treatment is scientifically proven to be effective in the treatment of heroin addiction, resulting in reductions in criminal behavior, lower medical and psychiatric costs, improved health, and lower rates of illicit drug use. A new medication for opioid maintenance, buprenorphine, can be dispensed by physicians in their offices, and shows promise as another treatment option.

In 2000, approximately 1.2% of U.S. residents ages 12 and over reported heroin use at least once in their lifetime, with approximately 104,000 new heroin users in 1999.¹ The White House Office of National Drug Control Policy estimates there may be as many as 980,000 users of heroin nationwide.² It is estimated that in 2000 approximately 30,665 Washington State adult residents were in need of treatment for heroin addiction.³ Most do not receive treatment. The National Institutes of Health estimate the financial costs of untreated heroin addiction to individuals, families, and society in the U.S. at approximately \$20 billion each year.⁴

People with chronic heroin addiction pose a significant public health risk to our communities. As a large majority are injection drug users (IDUs), heroin addicts are more likely to contract and spread HIV and hepatitis B and C. The federal Centers for Disease Control and Prevention estimate that IDUs (most of whom are heroin users), their sexual partners, and their offspring account for approximately 35% of new HIV infections each year.⁵ Chronic heroin users are more likely to engage in criminal activity, and are more likely to place increased strain upon public resources in welfare costs, emergency room and hospital admissions, and psychiatric hospitalizations.

Scientifically Proven

Methadone and other forms of opiate substitution have been shown scientifically to work effectively in the treat-

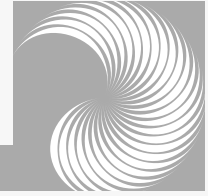
ment of heroin addiction. In its 2000 National Drug Control Strategy, the White House Office of National Drug Control Policy called methadone therapy “one of the longest established, most thoroughly evaluated forms of drug treatment.”⁶ A Consensus Panel convened by the National Institutes of Health (NIH) in 1997 concluded, “Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity.” A 1998 review by the General Accounting Office found that methadone therapy helps keep more than 179,000 addicts off heroin, off welfare, and on the tax rolls as law abiding, productive citizens.⁷

Seattle-King County – An Instructive Story

The experience of Seattle-King County is particularly instructive. In King County, it is estimated that there are between 15,000-20,000 injection drug users, 70% of whom are chronic heroin users and could benefit from treatment. From 1990 to 1998, the rate of heroin-related deaths in King County grew more than 170%. In 1998, there were more unintentional opiate overdose deaths in King County (143) than traffic deaths (119).⁷

Faced with an epidemic, city and county government undertook a coordinated response to address heroin addiction. King County authorized a 50% expansion in the number of opiate substitution treatment slots, and authorized a mobile methadone clinic. The County also provided preventive and limited substance-abuse treatment services in the local criminal justice system, and expanded the availability of drug-free housing for individuals in recovery.

One result was that heroin-related deaths in King County declined dramatically, by 57% to 61 in 2001. The rate of heroin-related deaths fell from 8.8 per 100,000 people in 1998 to 3.5 per 100,000 in 2001. Emergency room mentions of heroin similarly declined, from 78 per 100,000 people in



July-December 1997, to 38 in January-June 2001, representing a 51% decrease.

More recently, however, new treatment admissions have also declined, probably because effective treatment is resulting in longer treatment stays, and correspondingly fewer open treatment slots.⁸ There is now a waiting list of almost 700 people in King County at the Seattle Needle Exchange who have requested treatment (compared with fewer than 200 in 1997), but are unable to access it because of limited treatment capacity and sources of funding. Waiting time can be as long as two years or longer.⁸ The result is that, between 2001-2002, the number of heroin-related deaths rose from 61 to 87, representing a 42.6% increase.

The Situation in Washington State Today

Opiate substitution treatment clinics have been operating in Washington State for almost 30 years. As of August 2004, there are 16 opiate substitution treatment clinics operating in five counties. Six fixed locations and one mobile clinic are in King County, two of which serve only private-pay patients. Pierce County has two clinics (now operating as a single program), and Spokane, Yakima, and Thurston Counties each have one. There are two clinics in Snohomish County, one operated by the Stillaguamish Tribe. Clark County contracts with an opiate substitution treatment program in Portland, Oregon to serve its residents. The Veterans Administration contracts with two clinics (in Spokane and Yakima) to provide services, and, additionally, operates two clinics itself in the Puget Sound region.

As of January 1, 2003, 3,317 individuals were receiving opiate substitution treatment for heroin addiction, an increase of 1.3% over the same date in 2002. Of these, 1,703 (51.3%) were publicly funded.

Patient Profile

RCW 70.96A.420(4) requires DASA to provide an “outcome analysis” of programs providing opiate substitution treatment. In fact, DASA has been studying opiate substitution treatment for almost a decade and has established appropriate performance measures for evaluating cost effectiveness and efficacy.

The 2004 Report to the Legislature, *Determining the Value of Opiate Substitution Treatment* profiled patients receiving treatment on January 1, 2003. Among publicly funded patients, 54% were female, and 78% were white (non-Hispanic). Median age was 42 (with a range of 17-76), with 46% having children under age 18. Some 89% of publicly funded patients reported heroin as their primary substance of abuse, but all but 2% were also abusing other substances upon entry into treatment. Median age of first use was 16 (with the youngest being age 10), indicating that the average methadone patient had been using heroin for 26 years prior to current entry into treatment. Other studies indicate that most patients are likely to have had multiple prior entries into drug-free treatment for their addiction.

Treatment Works

A study was undertaken, as part of the Washington State Outcomes Project under the direction of Dr. Molly Carney, Alcohol and Drug Abuse Institute, University of Washington, of those admitted to opiate substitution treatment. The study was designed to evaluate the effectiveness of opiate substitution treatment. Some 135 adults admitted to publicly funded treatment at two Seattle-based methadone programs participated, with interviews administered at admission, and 6- and 12-months post admission.⁹

Some 11.9% of patients reported that their admission to opiate substitution treatment was prompted by the criminal justice system; 18.5% reported they were on or probably on



parole at time of admission. Legal pressure had no significant impact on patient length-of-stay (the average for those with legal pressure was 216.1 days; without legal pressure 242.3 days).

Treatment resulted in significant improvements among patients, at both the 6- and 12-month follow-ups. These included:

- **Increases in number of days employed** – There was a significant improvement in the number of days employed; from 2.4 days in the past 30 days at treatment admission, to 4.5 days in the 30 days prior to the six-month follow-up, and to 5.1 days in the 30 days prior to the 12-month follow-up. Average monthly income from employment rose from \$161 in the month prior to treatment admission, to \$330 in the month prior to the 12-month follow-up for those who remained in treatment.
- **Reductions in number of days engaged in illegal activity** – There was a large decline in the number of days engaged in illegal activity; from 21.1 days in the past 30 days to 2.1 days at the six-month follow-up, and to 2.5 days at the 12-month follow-up. For those who were still enrolled in treatment at the 12-month follow-up, days of illegal activity were reduced to 0.5.
- **Decreases in number of days of heroin use** – Days of heroin use were reduced from 25.0 in the 30 days prior to admission to 6.5 days for the 30 days prior to the six-month follow-up, and 5.4 days for the 30 days prior to the 12-month follow-up. For those who remained in treatment at 12 months, 85.5% were wholly abstinent from heroin.
- **Declines in number of days with medical problems** – Patients reported a small reduction in days of medical problems, from 12.5 days in the 30 days prior to treatment admission, to 11.1 days in the 30 days prior to

the six-month follow-up, and to 9.1 days in the 30 days prior to the 12-month follow-up (representing a 27.2% reduction). Many patients enter methadone treatment with long untreated medical conditions.

- **Reductions in number of days with drug problems** – Opiate substitution resulted in very large reductions in the number of days patients experienced drug problems. Some 65.9% reported a decrease in the number of days with drug problems between admission and the six-month follow-up. Patients reported 24.0 days with drug problems in the 30 days prior to treatment admission. This declined to 9.8 days at 30 days prior to the six-month follow-up, and to 7.2 days in the 30 days prior to the 12-month follow-up. Those still enrolled at 12 months reported only 3.6 days experiencing drug problems in the previous 30 days.

An interesting result of Dr. Carney's study, which has also been seen in other studies, is that it found a relationship between methadone dosing and treatment retention. The study examined two programs, with different mean peak doses: the first with a peak dose of 109.1 mg/day, the second with a peak dose of 83.1 mg/day. In the first program, average length of stay was 284.2 days, almost 50% greater than in the second, at 193.5 days. At 180 days following admission, 80.9% of participants in the first program were retained, while in the second, less than half (47.8%) remained. More research is needed to establish best practices in dosing levels specific to patients now being treated in Washington State clinics.

Challenges Ahead

Better treatment outcomes for opiate substitution patients are clearly tied to longer treatment retention. This poses a special challenge for providers and for the Division of Alcohol and Substance Abuse, as efforts to retain patients in



treatment longer mean that fewer patients are able to access treatment at all. Without increased capacity and funding, waiting lists continue to get longer. Not being able to provide treatment in a timely fashion to those who request it means a continuation of crime and criminal justice costs, higher emergency room and hospital admissions, and continued HIV and hepatitis B and C disease spread.

The King County Bar Association's (KCBA) Drug Policy Project is now spearheading advocacy efforts to expand the availability of opiate substitution treatment to all low-income, Medicaid-eligible individuals in the County. It is estimated that there are more than 700 such individuals in King County, and that providing methadone treatment for all of them would cost approximately \$2.56 million per year, half of which would be federal funds. KCBA is coordinating its efforts with a range of partners, including the King County Medical Society, Washington State Medical Association, Washington State Pharmacy Association, Seattle League of Women Voters, and Municipal League of King County. Representatives of the Drug Policy Project have been meet-

ing with the Governor's Office and key legislators and legislative staff to promote wider opiate substitution treatment access.

A second approach is to find ways to reduce demand for methadone maintenance treatment by intervening in the lives of patients before addiction has already become chronic and such treatment is needed. A new medication, buprenorphine, has been approved for dispensing through physician offices, once physicians have received the necessary training. Buprenorphine has shown effectiveness in studies conducted in other countries, provided appropriate counseling is also available as part of the treatment regimen. As of July 2004, the federal Substance Abuse and Mental Health System Administration reported that 35 Washington State physicians are now authorized to prescribe buprenorphine to opiate-addicted patients. The number of patients each physician can treat with buprenorphine is 30. It is reported anecdotally that the vast majority of patients being treated with buprenorphine have private health insurance coverage.

¹ Office of Applied Studies, *Summary of Findings from the 2000 National Household Survey on Drug Abuse*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2001.

² Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, 16. Washington, DC: Office of the White House, 2000.

³ This number was ascertained by taking the state adult population for 2000 and multiplying it by .007 (.7%), the percentage derived by the Department of Social and Health Services utilizing data from the National Household Survey on Drug Abuse.

⁴ National Institutes of Health, *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*, November 17-19, 1997.

⁵ Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*. Atlanta, GA: U.S. Department of Social and Health Services, Public Health Service, 1998.

⁶ Office of National Drug Control Policy, *National Drug Control Strategy: 2000 Annual Report*, 57. Washington, DC: Office of the White House, 2000.

⁷ Ibid.

⁸ Solet, D., Hagan, H., Nakagawara, J., Plough, A., and Ball, J. "Unintentional Opiate Overdose Deaths – King County, 1990-1999. *Morbidity and Mortality Weekly*, 49:29, pp. 636-640.

⁹ Banta-Green, C., et al. "Recent Drug Abuse Trends in the Seattle-King County Area", *Epidemiologic Trends in Drug Abuse*, June 2002.

¹⁰ Personal Communication, Dr. Michael Hanrahan, Seattle-King County Department of Public Health, June 2000.

¹¹ Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample – Final Report*. Olympia, W: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2003.

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Recognition of the close links between substance abuse and child abuse and neglect is growing. Yet, access to chemical dependency treatment for parents with children in the child welfare system remains difficult. The Division of Alcohol and Substance Abuse is now working with the Children's Administration to foster greater understanding and improve collaboration between the substance abuse prevention and treatment and child welfare systems.

Child Maltreatment 2002, a report issued by the U. S. Department of Health and Human Services, Administration for Children & Families, Children's Bureau, indicates there were an estimated 896,000 confirmed victims of child abuse or neglect in 2002, a rate of 12.3 per 1,000 in children in the national population. More than 60% experienced neglect; 20% were physically abused; 10% sexually abused; and 7% emotionally maltreated. An estimated 1,400 fatalities were attributed to child abuse and neglect, 76% of them children younger than four.¹ Every day hundreds of thousands of young people suffer the effects of family dysfunction, violence, homelessness, crime, and poverty that result from living in a household impacted by substance abuse. Experts agree there is a strong, frequently occurring correlation between parental chemical dependency and child abuse and neglect.

A 1999 report from the National Center on Addiction and Substance Abuse at Columbia University found that parental substance abuse causes or exacerbates seven out of ten cases of child abuse and neglect, and results in \$20 billion annually in federal, state, and local government spending. Children whose parents abuse drugs or alcohol are three times more likely to be abused and four times more likely to be neglected than are children of parents who are not substance abusers.²

In Washington State, the federal 2004 Child and Family Services Review found that substance abuse is the primary

Substance Abuse and Child Welfare

reason for opening 10% of the child welfare cases reviewed. Substance abuse was cited in 34% of the cases as the reason for children coming to the attention of the Washington Child Protective Services.³

Two Different Systems

The child protective services system and substance abuse prevention and treatment field operate with different goals, philosophies, and mandates. The highest priority of the child welfare system is to provide immediate protection for children, often beginning by removing the child from immediate risk of harm. Secondary goals are to move children into a stable environment as quickly as possible, and then, once the risk in the original home is eliminated, to attempt family reunification. Chemical dependency treatment, in contrast, is directed at assisting clients in controlling a chronic disease condition and helping them move through what is often a slow process of recovery.

Furthermore, accessing chemical dependency treatment in a timely manner remains difficult. Nationally, 67% of the parents with children in the child welfare system require chemical dependency treatment, but the child welfare agencies are able to ensure treatment for only 31% of them. Complicating matters still further is the difficulty in getting child welfare workers, already burdened by large caseloads, to document the impact of parental substance abuse on parenting and family functioning, for which they are not fully trained.

The 2004 Child and Family Services Review final report determined that there is a critical gap in service array in Washington State, particularly in the areas of mental health and substance abuse treatment. In addition, while research has shown that consistent exposure to parental abuse of alcohol and other drugs may contribute to the development of a child's own substance abuse problems, there is often a



critical lack of targeted developmentally appropriate substance abuse prevention services for children of chemically dependent parents. In short, there is much work yet to be done.

Future Directions

Staff from both systems should be provided with opportunities to learn about the other system. Training should include content on the interrelatedness of substance abuse and forms of family violence, such as child abuse and neglect. The substance abuse treatment workers need to have a better understanding of the child welfare system and the importance of family dynamics in support of reunification. In addition, child welfare workers need to have a better understanding of addiction and the recovery process. It is also important to increase interagency communication and collaboration between the two systems, working together with the client's best interest in mind. Case conferences should include all of the individuals who are working with the family. This includes sharing information and concerns about the clients.

The costs of parental alcohol and other drug use are incalculable and the scars of drug and alcohol spawned parental abuse and neglect is likely to be permanent. Through increased collaboration, education, and information sharing, both the child welfare system and chemical dependency system will be better able to serve the families impacted by substance abuse.

Recognizing common challenges and opportunities, in July 2004, the Washington State Division of Alcohol and Substance Abuse and the Children's Administration have drafted an interagency agreement to improve access to and use of chemical dependency treatment services for families, and prevention services for youth. Included in the agreement are commitments to develop a comprehensive and collaborative training plan to foster greater understanding of alcohol/drug-related issues, earlier identification of substance abuse, and more systematic intervention, including screening and treatment referral.

¹ Children's Bureau, *Children Maltreatment 2002*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, 2004.

² Reid, J., Macchetto, P., and Foster, S., *No Safe Haven: Children of Substance-Abusing Parents*. New York, NY: National Center on Addiction and Substance Abuse at Columbia University, 1999.

³ Children's Bureau, *Child and Family Services Review—Washington State*. Washington, DC: U.S. Department of Health and Human Services Administration for Children and Families Administration on Children and Families Administration on Children, Youth and Families, Children's Bureau, 2004.

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The links between tobacco use and chemical dependency are well-established. Smoking significantly increases the risks of death and disability among alcohol- or drug-dependent individuals, and may negatively impact recovery. The Division of Alcohol and Substance Abuse has launched a new initiative to address nicotine dependence within the substance abuse treatment delivery system.

Tobacco use is the leading cause of death and disability in the United States and in Washington State. Since the first U.S. Surgeon General's Report "On Tobacco and Health" in 1959, there have been more than 12 million deaths in the U.S. attributable to smoking. An estimated 8.6 million people in the U.S. have at least one serious illness caused by smoking. Each year, approximately 440,000 people in the United States die of a smoking-attributable illness. Among current smokers, chronic lung diseases account for 73% of smoking-attributable conditions. Excluding adult deaths from exposure to secondhand smoke, adult males lose an average of 13.2 years of life, and adult females 14.5 years of life as a result of smoking.¹

A large majority of current smokers (70%) report that they either want to quit, or have attempted to quit and failed.² While it is likely that some of the difficulty that individuals have in quitting is related to the social experience of smoking, the main reason for the difficulty is that one of the active ingredients in tobacco – nicotine – is a highly addictive drug. Researchers have discovered that nicotine raises the levels of a neurotransmitter called dopamine in the areas of the brain that produce feelings of pleasure and reward. Dopamine is the same neurotransmitter involved in addiction to cocaine and heroin, and researchers now suspect that changes in dopamine levels play a key role in all addictions.³

Historically, tobacco use has been accepted within the substance abuse treatment community. Nationally, more than

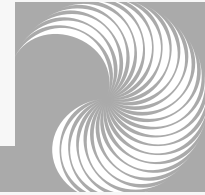
Treatment for Nicotine Dependence

80% of individuals addicted to alcohol and/or other drugs smoke cigarettes, compared with 23% of the non-addicted population.⁴ In State Fiscal Year 2003, 73.2% of adults and 58.1% of youth (ages 12 to 17) who received chemical dependency treatment funded through the Division of Alcohol and Substance Abuse (DASA) in Washington State were smokers. Acceptance of tobacco use has been based on the common assumption that individuals receiving chemical dependency treatment should achieve some success in dealing with addiction to their primary substance of abuse before attempting to quit smoking.

However, both the prevalence of tobacco use among those who are chemically dependent and research on the association between the use of nicotine and other drugs suggest that this is not a sound approach:

- Craving for nicotine appears to be linked to increased craving for illicit drugs among drug abusers who also smoke. The more cigarettes smoked, the more likely the individual was to use illicit drugs.⁵
- Compared with the risk for nonsmoking nondrinkers, the relative risk for developing mouth, throat, and esophageal cancer is seven times greater for tobacco users, six times greater for alcohol users, and 38 times greater for those who use both tobacco and alcohol.⁶
- Alcohol- and drug-addicted individuals who receive treatment and who also stop using tobacco products are up to eight times more likely to remain in recovery.⁷

Research indicates that up to 70% of recovering drug- and alcohol-dependent patients may be interested in receiving smoking cessation counseling and treatment. In SFY, 73.9% of adults smokers, and 67.9% of youth smokers (ages 12-17) who entered DASA-funded chemical dependency treatment had previously tried to quit. Clearly, a different approach is



called for, one that makes use of the skills and commitment of experienced chemical dependency treatment professionals in assisting their patients in going smoke-free.⁸ At least one study has shown that efforts to stop smoking are associated with improved chemical dependency treatment outcomes.⁹

New Life Nicotine Dependency Program

In 2002, the Washington State Department of Health (DOH) and DASA launched a new initiative to begin to address nicotine dependence within the substance abuse treatment delivery system. As part of this initiative, DOH and DASA jointly developed the *New Life Nicotine Dependency Program* to promote increased awareness of the importance of addressing smoking during chemical dependency treatment, and to provide technical assistance to treatment programs to help them incorporate nicotine-free policies and interventions for nicotine dependence. In June 2003, DASA began offering free nicotine addiction treatment training to program administrators, counselors, and support staff.

In addition, DASA and DOH, with strong assistance from Tacoma Community College, have inaugurated a Nicotine Policy Advisory Committee (NICPAC) to provide policy and guidance to chemical dependency treatment providers on the integration of nicotine use interventions into treatment. NICPAC advises DASA on training and policy needs; suggests changes in Washington Administrative Code (WAC) and contract language; recommends strategies for working with the Insurance Commissioner and Medicaid to ensure access to treatment for nicotine dependence; provides advice on funding resources that can be used as incentives for providers; and identifies successful programs and models that providers can use to attain success in nicotine-free facilities.

Patients who receive nicotine addiction treatment stand much to gain. A 50-year retrospective study of British physicians who smoke found that nearly all the risk of dying prematurely from smoking can be eliminated if people quit before the age of 30, and half the risk can be eliminated if individuals stop by age 50.¹⁰

¹ U.S. Surgeon General, *The Health Consequences of Tobacco Use*. Atlanta, GA: U.S. Department of Health and Human Services, U.S. Public Health Service, 2004.

² Centers for Disease Control and Prevention, *National Health Interview Surveys*. U.S. Department of Health and Human Services, U.S. Public Health Service, 2002.

³ Epping-Jordan, M., et al., "Dramatic Decreases in Brain Reward Function During Nicotine Withdrawal," *Nature* 393(76), 1998.

⁴ Ordor-Connors, B., "Addressing Tobacco in the Treatment of Other Addictions: The New Jersey Approach," UMDNJ-Tobacco Dependence (www.tobaccoprogram.org), 2004.

⁵ Frosch, D., et al., "Associations Between Tobacco Smoking and Illicit Drug Use Among Methadone-Maintained Opiate-Dependent Individuals," *Experimental and Clinical Psychopharmacology* 8(1), 2000;

Taylor, R., et al., "Tobacco Craving: Intensity-Related Effects of Imagery Scripts in Drug Abusers," *Experimental and Clinical Psychopharmacology* 8(1), 2000.

⁶ National Institute on Alcohol Abuse and Alcoholism, *Alcohol Alert* 39, 1998; Bethesda, MD: U.S. Department of Social and Health Services, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism.

⁷ Stuyt, E., "Recovery Rates After Treatment for Alcohol/Drug Dependence: Tobacco Users vs. Non-Tobacco Users," *American Journal on Addictions* 6(2), 1997.

⁸ Clemmey, P., et al., "Smoking Habits and Attitudes in a Methadone Maintenance Treatment Population," *Drug and Alcohol Dependence* 44, 1997.

⁹ Sees, K., and Clark, H., "When to Begin Smoking Cessation in Substance Abusers," *Journal of Substance Abuse Treatment* 10, 1993.

¹⁰ Doll, R., et al., "Mortality in Relation to Smoking: 50 Years' Observation on Male British Doctors," *British Medical Journal* 328, June 2004.